*The Fortnightly*
# REVIEW
*of*
THE CHICAGO DENTAL SOCIETY
*April 15, 1949* *Volume 17 • Number 8*

## Obtaining Longevity in Fixed-Bridge Restorations*

By B. F. Sapienza, D.D.S., Birmingham, Alabama

What I have to say today may be both surprising and shocking to many of you. When I say many of you, I am referring to the vast majority of dentists who started practicing after 1920. Those of you who practiced prior to that time will understand more readily many of the statements that I am about to make. In most meetings of a scientific nature we are concerned, and rightly, with progress; new things; new discoveries. What I am going to say very simply is that in one very important respect—restorative dentistry—I believe we should turn backward at least for twenty-five years for a good look to learn again some of the things we learned then and forgot for a while. About a quarter of a century ago many of us, and I reflect upon nobody, took a wrong turning. About that time men such as Dr. E. T. Tinker, Dr. J. E. Argue, Dr. DeForest Davis and many others were doing a magnificent job in fixed restorations in spite of all the many things that were said about the fixed-bridge. Among the leaders with criticism against the fixed-bridge was Dr. R. Ottolengui who at that time was editor of *Dental Items of Interest.*

Dr. Ottolengui came out in 1920 with the now absurd statement "that the technical requirements in the construction of a fixed-bridge appeared to be so exacting that they are beyond the capacity of a great majority of dentists and therefore should no longer be taught in the dental college." He, unknowingly, threw restorative dentistry back on its posterior parts for a quarter of a century. Dr. DeForest Davis once made the following statement in defense of fixed-bridge work and Dr. Ottolengui's accusations: "The trouble lies with the dentist himself and not the system."

The innumerable failures in the inlay-type bridge were blamed on lack of individual tooth-movement. This, plus the statement by Dr. Ottolengui, were contributing causes to this wrong turning. Thereafter followed the era of the removable bridge plus the many other types of restorations that cluttered the profession. The latest of these restorations that swept the country were bridges constructed with acrylics. We were looking for something better; we developed many restorations not so good.

It is not necessary for me to tell so well-informed an audience as this what a heavy price has been paid for faulty work of this kind. That is not to say that there have not been some real artists in this field—there still are. But there have been many wreckers. Let us forget the wrong turns and combine the teachings

*Read before the Midwinter Meeting of the Chicago Dental Society, February, 1948.

of men like Dr. Tinker and Dr. DeForest Davis with the knowledge we have accumulated during the past twenty-five years and start on a new road.

**SHELL-CROWN-BRIDGE**

The greatest asset of the old-fashioned shell-crown-bridge was longevity. Its greatest fault was that it lacked sanitation. The old-fashioned shell-crown-bridge was durable. Some of them gave service from fifteen to thirty years and sometimes even longer. Usually, they remained in position until a surface was worn through on the abutment crown thereby causing caries, or until affected seriously by periodontal disturbances. There was a definite reason for this longevity regardless of the span of the bridge. What was it? Today I hope to answer this question to your satisfaction. However, it would first, perhaps, be wise at this time to give you a résumé of historical facts pertaining to the old-fashioned shell crown.

The earliest form of abutment restoration known to us is the gold crown. There has been some controversy as to which of three men first made this type of restoration. Dr. Gustaf Larsen of Sweden, sometime between the years 1867 and 1869, made a crown which is reported to have remained in the patient's mouth for approximately sixty years.

Dr. W. N. Morrison of St. Louis made a crown in the form of a gold cap about 1869. This crown was somewhat similar to the one made by Dr. Larsen. Their method was to use a thin piece of pure gold, cutting it at the corners and giving it a slight lap for soldering after they had swaged it over a metallic die.

Dr. J. B. Beers of San Francisco obtained a patent for a crown in 1873. This crown was constructed by making a band and swaging the cap. As to which of these gentlemen actually made the first crown is of no great importance to us; our interest is chiefly in the length of time that the gold crown has been used as a restoration.

The gold crown constructed by these pioneers has been used by the profession for an astonishingly long time; approximately eighty years. It was not until 1917 that any marked changes were made in the original crown constructed half a century before; but in that year the cast jacket crown was first brought to our attention by Dr. C. B. Harris. Then later the shoulder of this jacket crown was eliminated and the cast gold crown resulted.

Long before the first cast crown was introduced, however, one of the most important developments in the history of dentistry had taken place: a fixed-bridge had been constructed. There is some controversy as to just who constructed the first fixed-bridge. However, in 1883, Dr. H. H. Johnson of Macon, Georgia, saw the full potentiality of the gold crown; he saw that by connecting two or more of them, a bridge could be made; and when Dr. Johnson cemented his first bridge into place, a new era in dentistry was born.

With the advent of the first bridge this so-called "old-fashioned" crown was now used both as an abutment restoration as well as an individual restoration. And, if the truth were known, after all these many years, this crown that we call "old-fashioned" is probably used more in the entire dental world of today than any individual gold restoration known to us.

As with the crown, so with the bridge, a surprising number of years passed before any marked improvement was made; not until about 1914 was there any change of great importance. But, in 1914, Dr. E. T. Tinker of Minnesota introduced the fixed-bridge constructed with porcelain pontics. It was this bridge which emphasized the need for sanitation in fixed-bridge restorations.

Some years before Dr. Tinker's porcelain pontic was introduced, another tremendously important restoration was being developed; the gold inlay was introduced by Dr. W. H. Taggart in 1907. This restoration, as we all know, was developed to take the place of the gold foil filling. However, the profession imme-

diately recognized the possibilities of using the inlay as a bridge abutment with the results ending in our modern inlay-type castings which are universally used.

It was a great victory for dentistry when the asset of sanitation was injected into the fixed-bridge; but the irony of this victory was that in gaining sanitation we lost longevity. Then, too, the span of the inlay-type bridge was limited.

#### LONGEVITY AND CLEANLINESS

I am sure we all agree that the two most important factors of a properly functioning restoration are longevity and cleanliness. It is obvious that the ideal restoration would be the one possessing these two qualities in the greatest degree. Unfortunately, however, a satisfactory combination of these two qualities has been exceptional in the average bridge restorations of the past. The reason has been too much stressing of frictional retention on castings used as bridge abutments.

When we construct an inlay-type restoration the more frictional retention we get the more accurately our restoration fits; the longer life we may expect from the *individual* restoration. However, when we take two or more of these accurately fitting inlays and add a pontic and solder them together, we have a different picture entirely. When an attempt is made to seat the inlay-type bridge into position, it usually meets with resistance due to some interference. Strain is created and in turn causes a disturbance of the normal resting position of the abutment roots. This strain is due to our present day ability to make each casting fit accurately, and our frequent inability to make them go to their exact place after we have added our pontics and soldered them together.

Now, for the moment, let us go back to the old-fashioned crown bridge. It is my contention that the two chief reasons for the long life of the old-type bridge were:

FIRST: The universal use of gold crowns as bridge abutments. These crowns afforded a protection from caries to all surfaces of the tooth, and usually remained in position until affected seriously by periodontal disturbances or from caries developed following an abraded surface.

SECOND: When the completed bridge was cemented into position there was no strain whatsoever on the abutment teeth; there was nothing to disturb the normal resting position of the abutment roots. This absence of strain was due to the particular design of the gold crown which, when properly constructed, fitted only at the gingival with a definite stopping point on the occlusal, leaving spaces between the prepared abutment and the inner surface of the crown to be taken up by cement.

From the foregoing it is obvious that frictional retention played no part whatsoever in the anchoring of this restoration. Therefore, it is reasonable to assume that the fact that no frictional retention was brought into play must have had some bearing upon the success of the old-type bridge.

You may recall that some years ago the profession, believing that lack of individual tooth movement was responsible for our failures, began experimenting with breaking the stress in the inlay-type bridge. The most popular of these bridges was the one designed with a rest. These bridges proved satisfactory.

It is obvious, therefore, that where no disturbances took place in the peridental membrane, our bridges were successful. This means that in constructing many of our bridges that have proved unsuccessful, we have concentrated too much effort in the design of the crown portion of our restorations and we have unknowingly ignored the very foundation upon which we are dependent.

The peridental membrane of each abutment root has been completely ignored in the design of a fixed-bridge. Longitudinal and horizontal fibers suspend the root within its socket and these minute fibers act somewhat like springs

in a shock absorber. In fact, they are nature's shock absorbers. There is a limit to the amount of stretching and punishment these fine fibers can take. Also, there are nerves and blood vessels entering the apex of each root. They, too, are limited in the amount of punishment they can tolerate. In short, we have completely ignored an important part in nature's design.

My contention is that the moment we throw the fibers of the peridental membrane out of balance with the vice-like grip of a fixed-bridge we are inviting trouble. Each bridge restoration, no matter how constructed, must go to place with finger pressure. It must go to place without disturbing the relaxed position of these fibers. This can be done by taking the unique superiority from the old-fashioned crown and using this in our modern castings that are to be made bridge abutments. This means that all castings used as bridge abutments should be designed for maximum anchorage and a minimum of frictional retention.

**FRICTIONAL RETENTION**

If you insist on frictional retention, extreme care must be taken so that your fixed restoration does not create a strain on the peridental membrane. If this is encountered, the stress should be broken where possible. If the span is too long and it is not desirable to break the stress, then castings used for abutments should be designed with a minimum of frictional retention. If you dare to dispense with frictional retention, it can be done. Frictional retention can be relieved throughout the entire casting with the exception of the finishing line; however, care must be taken to design a definite stopping point on the occlusal area. This stopping point, of course, is to stabilize the casting in its exact position. These are some of the ways: relieve the wax pattern before casting; use aqua regia; revert to the popular method of relieving the inner surface of castings with burs and stones; and, in some instances, where the indirect method is employed, apply tin foil. This tin foil, of course, is peeled away from the wax pattern before casting.

But, even though I hold to the cast crown for longevity, there are ways, good ways, to strengthen and lengthen the life of other types of restorations. I do not expect all of you immediately to take up the methods or the techniques I suggest to you. You have your own ideas. You have your own proved methods for constructing successful restorations. If I can be helpful to you in these methods, I am eager to do so. Let us take up the restorations commonly used. Now here is what I have really been getting at all this time. I am now going to lay it right on the line.

For longevity I suggest the use more often of the full-cast-crown in the posterior of the mouth; a cast crown designed without frictional retention. I shall explain more about this crown later. With the crown as a posterior abutment and without frictional retention, you may use a restoration of your choice toward the anterior part of the mouth, eliminating as much frictional retention as possible in the anterior restoration. This freedom between the prepared abutments and the inner surface of your castings will give you the nearest approach to the asset we had in the gold shell crown.

Now, for the moment, let us discuss the restorations that are most popular with us. There is the two-surface inlay. We all know that the two-surface inlay was developed to take the place of the gold foil filling. The two-surface inlay after much experimentation over the years cannot, in my opinion, take the place of a well-constructed amalgam restoration, let alone the gold foil filling. You have been flooded with literature on making accurate castings for a quarter of a century. The well-constructed inlay of today with all the innumerable techniques employed is probably no better than the castings made by discriminating and competent dentists of a quarter of a century ago. And the good inlay of today is still

made by the expert and not the average dentist. This same condition existed twenty-five years ago. Think it over, fellows. Therefore, it is my belief that the two-surface inlay should seldom be used as an abutment restoration, for in most instances, even where there is no strain present, it is unable to withstand the stresses to which it is subjected, and the result is disintegration of cement and leaky margins. Undoubtedly, the two-surface inlay conserves tooth-structure at the time of the original preparation but unfortunately, this does not afford a protection from caries to the remaining surfaces of the tooth; and when caries attacks the opposite proximal space, the result is that the entire bridge must be removed before the damage can be corrected. The necessary removal of the bridge, of course, is the lesser misfortune that can result from the use of the two-surface inlay; the greater misfortune is that sometimes a patient through ignorance will neglect decay until the pulp is involved and this may result in the loss of a tooth. Thus our kind attempt to conserve tooth-structure eventually harms the patient by causing him to lose a tooth and harms the dentist by causing him to lose professional prestige.

When the inlay is used, the m.o.d. inlay is preferable to the two-surface inlay. It eliminates the possibility of caries attacking the tooth in the opposite proximal area, thereby adding to the longevity of the restoration.

There are innumerable other types of abutment restorations with designs that call for slots, slices, pin-holes, etc., but if the average dentist is to master a technique whereby he may eliminate frictional retention and still have sufficient anchorage, he may do well to adhere to simplicity in the preparation of a tooth for the reception of an abutment restoration. It is advisable to use an abutment restoration which affords the necessary amount of anchorage, but which in no wise endangers the pulp.

Where aesthetics is involved we suggest the use more often of the three-quarter crown. The three-quarter crown is preferable to either the two-surface or m.o.d. inlay for with it more anchorage may be obtained, less depth is necessary in the preparation of the tooth, more tooth-structure is protected from future caries, and the marginal line to perfect in a three-quarter crown is approximately one-third less than that of a m.o.d. inlay and it can be designed with a minimum of frictional retention.

Just as this paper maintains that the three-quarter crown is the best restoration where aesthetics is involved, so it holds that the full-cast-crown is the greatest abutment restoration yet developed where appearance is not involved.

### THE FULL-CAST CROWN

Since the full-cast-crown is the latest development in the gold crown, and since maximum longevity was evident when the old-type crown was used, it is reasonable to assume that the most successful bridge possible, where appearance can be ignored, would be one constructed with two full-cast-crowns used as abutments, provided we could in some way design these cast crowns to eliminate frictional retention. If we could do this we would then have the greatest type of bridge restoration possible for that part of the mouth where aesthetics is not involved. This can be done. I am certain of it. I have been doing it for approximately twenty-five years.

My suggestion for the more frequent use of the full-cast-crown in the posterior of the mouth will, of course, be frowned upon by many operators who favor the inlay-type restoration; but I feel very strongly that these inlay restorations, used as abutments, are still very much in the experimental stage when compared with the full-cast-crown.

Frankly, I believe that most of us will recall how, in those moments of regret that come to every sincere operator, our feeling is deepened by memories of inlay restorations which we have tried with

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# EDITORIAL

### THE DENTAL SOCIETY IS YOU

On every hand when the Dental Society is discussed by individual members, it is apt to be considered as something apart, a sort of secret order frequently referred to as "they." It seems to be the great American custom, this habit of referring to our agencies as "they." People almost always refer to the Government as "they"; perhaps that's one of the reasons we're engaged in our present struggle for survival as an independent profession.

But to get back to the Dental Society—the "they" referred to above are fellows just like you, same education, same background, only endowed with that indefinable something that bids them make a sacrifice of both time and money, in order that your Dental Society may rank high in the opinion of the public and of the profession at large.

We publish elsewhere in this issue a group of letters picked at random just to prove to you that your Dental Society is held in high esteem by those outside our immediate environs. The writers of these letters are well known to most of you. Their sincerity cannot be questioned. They, too, came up the hard way, serving in various capacities in their component societies and finally gaining national recognition. It can safely be said that no one of them could have attained his present high estate without the invaluable experience of serving in the ranks.

That's American for you; everyone of you has an equal opportunity to serve. All you need do is grasp the opportunity when it is offered. You then become "they."

### SOMEONE FINALLY TAKES OUR SIDE

After reading the various "feature" articles that have been appearing in print lately, most of which criticize the profession, it is refreshing to pick up the March issue of *Harpers* and find a reporter who takes our side. In a story entitled "How to Keep Away from the Dentist," Herbert Yahraes, a former newspaperman now writing articles on medical and scientific subjects, shows that he consulted dental authorities before rushing into print. That's a complete reverse of the ordinary procedure. The author usually waits until it is too late to make a change and then sends his article into the American Dental Association for its approval. He doesn't care too much whether he gets the approval; he just goes through the motions.

Mr. Yahreas quotes various authorities, notably Dr. Philip Jay of the University of Michigan, Dr. L. S. Fosdick of Northwestern, and Dr. Isaac Schour and Dr. Maury Massler of Illinois. He publicizes the latters' research project among the children of Naples. He draws the conclusion, when all is said and done, that the surest way to eliminate caries is by cutting down on the intake of sweets. But as Dr. Fosdick puts it, "Very few individuals are sufficiently interested." People like sweets and they are going to eat them whether or no. Mr. Yahreas hopes that someone, someday, will find "something that can be added to sugar to prevent caries just as iodine is added to salt to prevent goiter." It's just possible that we'll live to see it in our generation.

## LYING DOWN ON THE JOB

Latest reports from Washington indicate that the incoming mail has been so heavy that members of Congress are literally swamped by it. As might be expected, union labor is particularly aroused. The extension of social security and the initiation of compulsory health insurance may take a back seat momentarily while the effort is being made to repeal the Taft-Hartley law, but when that issue is settled, watch them turn on the pressure.

In the meantime these same reports indicate that both the medical and dental professions are lying down on the job. Our leaders are in there doing what they can, but the flood of protest, that was expected, has turned out to be a mere trickle. Outsmarted by professional politicians, such as Oscar Ewing, we stand to lose the battle. When we awaken to the full possibilities of the socialized program, we may find that our future is fully and effectively compromised as the result of our lack of effort. Write your Congressman NOW.

## THE FIGHT AGAINST CANCER

The American Cancer Society is currently engaged in a drive to obtain funds to fight cancer. Combating the rising toll of fatalities from this dread disease presents many problems. Even after decades of study, cancer remains a deep mystery and hundreds of research projects are being financed by the Society in an effort to lick it. Research workers do not talk much about new discoveries and the sad truth is that there are still only three standard treatments—surgery, x-ray and radium. Nevertheless, thousands of substances are being screened as possible cancer cures and someday research will solve the puzzle.

It is a bitter fact that each year 47,000 people die because they don't know enough about cancer to be concerned—until it is too late. The American Cancer Society's program hinges on these needless deaths. Its fund campaign means that more and more people can be informed. Millions of pamphlets describing the dangers, symptoms and cure of cancer are distributed to everyone who can be found who might be interested. Movies are shown in schools, meetings and theaters. A speaker's bureau with qualified personnel schedules free appearances before civic, social and industrial groups. Since nearly one-half of the cancers that occur in the region of the mouth are first seen by dentists, a professional program has been set up to include them.

Along with its educational and research projects, the American Cancer Society has a service program for prospective and present cancer victims and will devote a considerable part of the money raised to service projects in Illinois.

Information centers where the public may come for accurate information about cancer and cancer services, and detection centers where apparently well persons may be examined for signs of cancer, have been established in Chicago. There are 6 diagnostic clinics in the Chicago area, as well, which receive assistance from the American Cancer Society.

The goal for the Chicago area drive is $625,000. Continuance of the activities enumerated above is dependent upon the achievement of this goal.

# LETTERS

February 10, 1949.

Dr. Robert J. Wells, President
Chicago Dental Society
1525 East 53rd Street
Chicago, Illinois

Dear Bob:

My appreciation to you and the Chicago Dental Society for the courtesies extended me during my recent visit to the Windy City.

Doctor Zinser and his committee are tainly to be congratulated for putting on another splendid Midwinter Meeting. The "boys" I ran into all seemed to like the show very much and some of my acquaintances among the exhibitors expressed much satisfaction and sometimes their remarks we have found are very indicative.

Thanks again, and best wishes for continued success.

Sincerely,
*Percy T. Phillips, Speaker*
*House of Delegates*
*American Dental Society*

February 14, 1949.

Dr. Robert J. Wells, President
Chicago Dental Society
1525 East 53rd Street
Chicago, Illinois

Dear Dr. Wells:

I want to thank you again for the many nice courtesies extended me while attending the Chicago Dental Society Meeting. I always enjoy attending this meeting as it is the best in the country.

Many thanks again and with kindest regards, I am

Sincerely,
*E. Jeff Justis, D.D.S., Sec'y.-Treas.*
*Tennessee State Dental Association*

February 17, 1949.

Dr. Robert J. Wells, President
Chicago Dental Society
1525 East 53rd Street
Chicago, Illinois

Dear Bob:

I wish to thank you for the many courtesies shown me during my stay in Chicago.

I would also like to congratulate you on having one of the best meetings the Chicago Dental Society has ever held. I am not naive enough to believe that such things just happen. It represented a lot of sound thinking and hard work on your part.

With all good wishes, I am

Cordially yours,
*Clyde E. Minges, President*
*American Dental Association*

February 21, 1949.

Dr. Frank Farrell, Chairman
Midwinter Meeting Program Committee
Chicago Dental Society
30 North Michigan Avenue
Chicago, Illinois

Dear Dr. Farrell:

It was indeed my pleasure to appear on your program and sincerely hope the little that I did will bear some fruit.

I thought the meeting an excellent one and heard so many praise your program. You did a wonderful job and should be well congratulated.

Thanks again for all the kindness extended me by your Society and I will look forward to being with you again next year.

Cordially yours,
*Robert L. Dement, D.D.S.*
*Atlanta, Georgia*

# Elections Committee Announces Rules for Election of Officers April 19

Polling Place—North Assembly Room, Stevens Hotel

Polls Open from 6:30 to 10 p.m.

The Elections Committee is charged with the responsibility of managing the annual election of officers of the Chicago Dental Society. Authority for this is to be found in Article XVII of the By-Laws and, in accordance therewith, the committee met on March 31 to formulate rules, regulations and procedures for the election to be held at the Stevens Hotel on the evening of April 19.

**TIME AND PLACE**

The polling place or place of election will be the North Assembly Room, located on the third floor of the Stevens Hotel. Polls will be open from 6.30 p.m. to 10:00 p.m. on the day of the election, April 19.

**ELIGIBILITY TO VOTE**

All active members in good standing holding 1949 membership cards are eligible to vote. Those who have not paid their 1949 dues may do so at the Registration Desk adjacent to the polling place and thus qualify for voting privileges. All eligible voters must be present in person to cast a ballot.

**REGISTRATION**

Voters will be registered at the time of casting ballot and will be given an identifying badge enabling them to attend the scientific session by one of the judges.

**NOMINEES FOR OFFICE**

Two candidates have been nominated for each of the elective offices of the Society pursuant to Article IX of the By-Laws. The nominees are: President-Elect, Arno L. Brett and LeRoy E. Kurth; Vice-President, Paul A. Edmand and Samuel R. Kleiman; Secretary, Edwin W. Baumann and Paul H. Wells; Treasurer, Elmer Ebert and Kenneth W. Penhale.

**VOTING FACILITIES**

Regulation voting booths and ballot box will be used, thus assuring every voter complete secrecy.

**MARKING OF BALLOTS**

In order that there may be no misunderstanding as to the manner of marking ballots, the By-Laws are quoted on the subject—*Article X, Section 3. Marking of Ballots: Voters shall place a cross, the lines of which must intersect within the square, opposite the name of such candidates for whom they desire to vote. Any defacing or unofficial writing upon a ballot shall invalidate such ballot.* Accordingly, all ballots, to be counted, must be marked thus ☒.

**GENERAL RULES**

No loitering in or about the polling place will be permitted. Voters are asked to leave promptly upon casting their ballots.

**CONCLUSION**

These regulations have been adopted pursuant to the By-Laws and have been prepared to assure a smooth election operation. The cooperation of all members in their observance will be greatly appreciated.

Election Committee
G. C. JOHANNES,
*Acting Chairman.*

# NEWS AND ANNOUNCEMENTS

## 108TH MEDICAL BATTALION TO STAGE LECTURE

On April 27 at 9 p.m., the 108th Medical Battalion will present a lecture on Maxillo Facial Surgery at its Officers Club, 1551 North Kedzie Avenue. Dr. Orrin H. Stuteville, who is in the Department of Maxillo Facial and Oral Surgery at Cook County Hospital, will be the speaker.

During World War II, Dr. Stuteville did considerable work in the Maxillo Facial and Plastic Surgery fields. He is now teaching these subjects at Loyola University.

The battalion commander, Lt. Col. John R. Tambone, M.C., has issued an invitation to the members of the Chicago Dental Society to attend this lecture.

## CLEVELAND DENTAL SOCIETY ANNOUNCES MEETING

The Cleveland Dental Society announces its "Annual Spring Clinic Meeting" on May 2, 3 and 4 at the Hotel Hollenden, Cleveland, Ohio. The three-day meeting will offer the best essayists and clinicians available, rounded out with commercial and visual education exhibits.

A cordial invitation to attend has been issued to the members of the Chicago Dental Society by the Cleveland Society.

## PERIODONTIA IV POPULAR COURSE AT ILLINOIS

In response to a great number of requests, "Periodontia IV," the popular evening course, will be offered again by the University of Illinois College of Dentistry. This course, dealing with the histopathology of the periodontal structures, will be in charge of Dr. Balint Orban and will run for six consecutive Thursday evenings beginning April 21 from 7:30 to 9:30 p.m.

## TIME FOR ACTION

*(Editor's note: The Unit Instructor of the Medical Reserve, Major John C. Keele, Jr., is the author of this thought provoking article.)*

The implementation of the principles of deeper military knowledge plus the true story of what happens to men when the veneer of civilization is stripped away can and should be presented to *young dentists* and *experienced dental reserve officers* and others who have suffered the pains of war. Action in this direction will make for contributions of incalculable value to the prolongation of the lives of our citizens and future soldiers. It will reflect credit upon *American Dentistry* and enhance the heritage, sacred trust and exacting responsibility of our forefathers.

Specifically, there is a genuine need for an educational program to alert the younger members of the profession to the magnitude and extent of what is meant by deeper military knowledge. Therefore, dentists with previous military experience are needed now for the *active reserve* with the view in mind of bringing unity and coordination into activities and at the same time for direct medico-military association with members of the profession who have not yet had the privilege of active duty in the Armed Forces of this great land.

Service may be rendered without upsetting medical economics. For example, hospitals might well arrange symposiums for the benefit of their resident staff in which medical aspects of the next emergency receive special attention. Appropriate follow-up material could be furnished. In this and other ways young doctors could be made ready, alert and united in their desire to play a part in securing the peace of this era.

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# NEWS OF THE BRANCHES

**WEST SUBURBAN**

Our president, Bernie Siegrist, arrived back safe and sound from Mexico. He didn't have a very good time because of the bad effects of the Mexican food. Maybe the next time Bernie goes there, he'll take his own commissary with him. . . . Milo Lunak's son, Thomas, recently married Miss Lorraine Johnson, daughter of Mr. and Mrs. Harry T. Johnson of Maywood. The ceremony took place in the First Congregational Church of Maywood. The couple will live in Milwaukee, Wisconsin. . . . Freddy Hawkins and Vernon Hauff drove down to Florida for a sunny vacation. Freddy expects to stay about ten days but Vernon is going to be gone a month. . . . John Sonnenberg's wife and son, John David, left for a month's vacation with Mrs. Sonnenberg's parents in Salt Lake City. . . . Walt Luehring will soon be moving into new quarters in the Oak Park Arms Hotel. It seems that Walt decided that he has been in the old location too long and that it is time for a new slant on things. Good luck to you, Walt, in your new spot! . . . Arnold Pins is retiring from practice. He is leaving for a month's vacation and a much-needed rest. Hot Springs is one of the spots on his itinerary. Arnold tells me that he decided he had just about enough "looking down in the mouth," so he is going to occupy a nice chair in the Oak Park Federal Savings and Loan Association. Good Luck, Arnold! Our branch regrets losing a very loyal member as well as an excellent dentist. Don't forget West Suburban Branch, Arnold; drop in and see us once in a while. . . . Ed Hall will be occupying Arnold's former office. . . . Dr. Robert A. Atterbury comes to West Suburban Branch from the North side. He has recently opened an office at 1011 Lake Street and is specializing in oral surgery. *—E. G. Walters, Branch Correspondent.*

**NORTH SIDE**

With the threat of socialized dentistry in current legislation, our Northsiders will be interested in the many programs that are being offered to keep us informed. A copy of the National Health Insurance Bill S. 5 may be secured by sending a request to either Senator Lucas or Senator Douglas in Washington. With this on hand, we will be able to better analyze Harold Hillenbrand's talk to us at the North side meeting. Other talks on the subject are to be presented at Loyola University Homecoming on April 25 and 26 by Dr. Joseph Lohman of the University of Chicago and Dr. Allen Gruebbel, secretary of the Council on Dental Health of the American Dental Association. . . . Freddie Schultz and Roger Stockton are preparing for the golf outing. They are down in New Orleans for some preseason practice. . . . New officers of the fast growing Uptown Study Forum are Rudy Kadens, president; Harold Sitron, program chairman, and Joe Solow, secretary-treasurer. . . . Marv Treiber, outgoing program chairman of the above group, just participated in a program as bridegroom. His lovely bride, Florence, hails from Springfield. . . . Fred Dainko, an instructor at Chicago College of Dental Surgery, has located at Devon and Western. Good luck, Fred! . . . On discovering he was coming down with mumps, Joe Stillerman exclaimed, "Aw Nuts!" . . . The stork has been working overtime on the North side. The Abe Hoffmans have just had a 6-lb., 13-oz. baby boy to fill their new home. Your correspondent recently enjoyed a housewarming there. Jonathan Ellis is the little mite of an orthodontist born to Dr. and Mrs. Carl Asher in March. . . . For every gain there seems to be a loss; our condolences to Chick Gold on the loss of his father on March 29. . . . Good things

have happened to the Joe Solows; first a new car, then a new apartment. . . . We take this opportunity to wish the new officers of our North Side Branch the best of luck for the coming season. . . . We will look forward to bigger and better programs with an increased attendance. —*Paul Brown, Assistant Branch Correspondent.*

**NORTH SUBURBAN**

The middle of April always brings out the athlete in us and we are busy polishing our putter and dreaming of driving on the green. . . . Thus far we have received not one little unwitnessed account of life on the fairways and in the traps which would evoke the slightest little gasp of amazement or raise our practiced left eyebrow even a quarter of an inch. However, if our literary devotees will have patience, we promise to get out and report first-hand the initial tee-off of the season between our two favorite competitors, Gene Stearns and Zenas Shafer. . . . Also in the next issue, be sure to see an account of the first Bingo Bango Bungo—an ancient contest of chance and skill now indulged in by many. . . . Having thus far successfully camouflaged our lack of news with editorial musings, we herewith present the total of correct and incorrect information gleaned from all twelve of our little helpers (who should bear in mind that it is nearing the time when we *suggest* our successor), four or five salesmen, and a cleaning lady who services several offices within our ken. . . . Our late-season Florida travelers include J. P. O'Connell, Claude Richards and Jim Plants, who will be gone about a month—far short of the record set earlier by Bill Mayer. . . . And the trek back includes "Steve" Stephenson and Pinky Stine (and now we understand the nickname). . . . We close this little gem with a quote from the English author, Sir Roger L'Estrange, "Though this be play to you, 'tis death to us" (or vice versa). . . . Happy Easter Bunny to you all.—*G. A. MacLean, Branch Correspondent.*

**KENWOOD-HYDE PARK**

"Socialized Medicine and the American Dental Association" will be the topic of an address to be given by Dr. Harold Hillenbrand, Secretary of the American Dental Association. This is probably the most important problem that confronts the profession today and we are indeed fortunate to have Dr. Hillenbrand as our speaker, for he is not only very close to the problem but is an extremely able speaker. Ladies are invited for the matter is also important to them. Plan to have dinner with your best girl that night, May 3 at 6:30. Mark off that date right now. . . . Ben Herzberg has gone to sunny Arizona to visit and to teach at the Tweed School of Orthodontia in Tucson. . . . Gramps Libberton will appear before the Eastern Iowa Dental Society of Davenport, where he will present a paper on full denture construction. . . . Syl Cotter and Ed Budill took time out for a little post-graduate study in general anesthesia at Akron, Ohio. . . . While on the subject of anesthesia, Ken Johnson has completed his post-graduate course in general anesthesia at St. Mary's of Nazareth Hospital and has now begun his year's residence in oral surgery at County Hospital. Lots of luck, Ken! . . . Bob and Mrs. Wells made a trip to Natchez and Gulfport, Mississippi and Mobile, Alabama and had a most enjoyable time. They toured a good many of the old plantations. . . . Mayor Bressler of Palos Park and Clarence Davies are headed for Florida and points south. They expect to do a little fishing and to visit Dr. Mitten, an old Kenwood member who now lives at Monticello, Florida. Have some good fishing, boys. . . . Larry and Mrs. Mullineux are Florida bound, also. They expect to absorb the Florida sun around Fort Lauderdale. . . . Joe Wiener has forsaken the ranks of bachelorhood and became a benedict recently. Our best wishes to the bride and groom for many years of happiness. . . . To the officers, committee chairman and committee personnel, we owe a very sincere "thank you" for a job well-done. Our dinner attendance has been excel-

lent, our programs very good and a fine spirit has been in evidence all year. To each of you who have done so well, our sincere appreciation; to the new officers who will be installed at the May meeting, our best wishes for an even more successful year. . . . Our director to the Chicago Dental Society, Walt Dundon, has done a grand job of keeping us informed and up-to-date. . . . To Robert Wells, President of the Chicago Dental Society, the thanks of Kenwood for a most successful year. We are proud of the job you did, Bob. . . . For dinner reservations telephone Stan Wrobel at PLaza 2-6020. . . . My newshawks were much better this time; thanks, boys! . . . Any news telephone me, SOuth Chicago 8-1823.—*Elmer Ebert, Branch Correspondent.*

**NORTHWEST SIDE**

Spring is in the air and we can soon look forward to getting out our golf clubs and closing our offices for a few hours of relaxation each week. . . . Early last year your correspondent was complaining of the lack of news items at one of our meetings and jokingly suggested that some of the members should have babies so we could have something to write about. It's a great pleasure to announce that Fred Ahlers cooperated and became the father of an eight-pound boy on Sunday, March 27. Our heartiest congratulations to Fred and Mrs. Ahlers and the new addition. . . . Bob Placek is making his regular trip to Hot Springs, Arkansas, along with Chester Stypinski. . . . A broken foot is keeping Howard Anderson on the sick list for a few weeks. . . . Folmer Nymark expects to be back in his office after Easter. He was recently operated on and has been recuperating at home. . . . The annual election of the Chicago Dental Society is keeping Gus Johannes busy with his job as Chairman of the Election Committee. . . . Your correspondent met his classmate, Leo Wasielewski, at an Army Medical Reserve meeting recently. . . . A three weeks' vacation in Sarasota, Florida was a good excuse for LeRoy Maas to get away from the wet weather of Chicago recently. . . . John Dybdahl and his wife also went South for a couple of weeks, to New Orleans. . . . Start making plans now for our big affair of the year: The Annual Ladies' Night promises to be a big social event for all the members and their wives. It will be held on Wednesday, May 18, at the Fireside Restaurant, Lincoln and Touhy Avenues. The program committee has promised us a private dining room, punch bowl and all the other things which go to make this affair the success it always is. Mark your appointment books now and check the date. The time is seven o'clock. . . . Cas Rogalski spent a few days at Passavant Hospital for a checkup recently. . . . M. V. Kaminski has been spending all his spare time remodeling his home. . . . The Northwest Branch will be well-represented at the coming annual election of the Chicago Dental Society. One of our popular members, LeRoy Kurth, is a candidate for the office of President-Elect. LeRoy is well-known for his work in the field of full denture prosthesis and has lectured on that subject before many of the dental organizations. The Dental Society election will be held on Tuesday, April 19. This is your opportunity to get out and vote for the candidate of your choice.—*Toby Weinshenker, Branch Correspondent.*

**WEST SIDE**

Reports of spring are in!! What with the aching backs from spring cleaning, early gardeners and the first rounds of golf for 1949. . . . The Lawndale Dental Club held its monthly meeting on Tuesday, April 12. A good outdoor hunting and fishing movie was shown, setting off the spring and summer fishing urge. . . . Irving Chrastka is flying down to Key West to take over where President Truman left off, doing some deep-sea fishing for those denizens of the deep. Watch out for those sharks, Irv! . . . Our branch has just gone through the ceremonies of

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resulting failure and often with irreparable damage, causing loss of teeth to the patient, and loss of prestige to ourselves, and to our profession. These regrets can be lessened, if not eliminated entirely, by the use of the full-cast-crown. Some of the advantages of the full-cast-crown are:

1. Better than any other form of abutment, the full-cast-crown has strength to withstand the necessary stresses.
2. The necessary preparation of a tooth for the crown is less difficult than that for any other form of abutment.
3. Greater anchorage may be obtained with less destruction of tooth-structure.
4. The completed crown affords a protection from caries to all surfaces.
5. The necessary preparation is always at a safe distance from the pulp.
6. In the preparation of the tooth, the destruction is confined to virtually one tissue: the enamel.
7. The amount of tooth-structure destroyed in the preparation is no more than the amount sacrificed in the preparation for a three-quarter crown, m.o.d. inlay, and m.o.d. inlay with lingual and buccal extensions.
8. The preparation of the tooth requires less time, thus, of course, lessening trauma and shock to the pulp.
9. The crown is of particular value as a restoration for short teeth.
10. The marginal line necessary to perfect in the full-cast-crown is approximately one-third less than that of a three-quarter crown and one-half less than the marginal line required by the m.o.d. inlay.

With all its advantages, however, the full-cast-crown lacks one very important factor: it lacks aesthetics. This lack is never so obvious as when we are confronted with the task of using upper mutilated anterior teeth as bridge abutments. And yet, for even these teeth, a full-cast-crown can be constructed, provided the crown is designed on the buccal or labial surfaces for the reception of a porcelain veneer.

### TECHNIQUE FOR CONSTRUCTION

The technique I am using for constructing a full-cast-crown without frictional retention has, I believe, an advantage over the method commonly used. The crown I am suggesting can be made by the direct method. However, the operator can still use a die if he so desires. The construction of this crown is simple, and, when completed, fits only at the gingival with a definite stopping point on the occlusal surface. This stopping point prevents the crown from being driven past the gingival finishing line when placed in position. The technique is as follows:

After a dentimeter measurement has been taken of the prepared tooth, a rectangular piece of 24 carat 38 gauge gold, approximately three-eighths of an inch wide, is cut slightly shorter than the measurement. This strip of gold is then made into a band by joining with either 18 or 20 carat solder. The band is then placed on the tooth and contoured to the gum line, making sure that it extends beyond the finishing line without impinging on the gum tissue. If the band does not fit snug at the gingival it should be cut shorter and resoldered.

The completed band should extend beyond the occlusal surface. The next step is to cut a V-shaped groove at the disto-lingual, disto-buccal, and mesio-lingual and mesio-buccal corners of the band. These four V-shaped cuts will create a small flap on mesial, lingual, buccal, and distal which may be folded over on the occlusal surface. These flaps, however, must not cover the entire occlusal surface. A small space of visible tooth-structure must be left for a reason which will be explained later.

The thimble-shaped matrix is now removed and the four corners reduced with a Joe Dandy disk to eliminate too much bulk when waxing the pattern. We now

continue by covering this thimble-shaped gold matrix with inlay wax, including the hole in the center. Place it back in position; heat the occlusal surface with a chip-blower and have the patient bite into centric occlusion. When the patient bites into the soft wax, the wax will automatically come in direct contact with the exposed tooth-structure on the occlusal. Chill the pattern; remove and carve; replace on the tooth and adjust contact point.

The next step, which is the most important in this technique, must be carried out very carefully. With a sharp lance expose sufficient wax to form a small apron of 24 carat gold about two millimeters in width around the entire circumference at the gingival. It will be remembered that in the beginning we extend the 24 carat gold band beyond the gingival finishing line. This was done to enable us to obtain accurate results with the burnishing technique which follows:

Burnish the exposed apron on the buccal surface against the finishing line and over any undercuts. Lift the pattern straight off the tooth and if it does not come off easily, if it meets with resistance, the resistance is owing to undercuts beyond our finishing line and the pattern should then be lifted and tilted bucally to facilitate its removal. Upon removal of the pattern a close examination will reveal a definite mark along the exact path of the finishing line. Trim excess gold to this line. Replace and reburnish. Again lift the pattern straight up. If we meet with no resistance, interference from undercuts has been eliminated and we then know the gold is in direct contact with the tooth-structure at the finishing line.

We proceed in the same manner on the mesial, distal, and lingual surfaces. When the pattern is treated as I have outlined, and when it can be removed without any resistance, we are then ready to re-wax the exposed apron. The crown is then sprued and cast in the usual manner.

So far this paper has made a number of suggestions as to what can be done to obtain more longevity in our fixed restorations. However, there is one most important fundamental principle which we must not overlook and that is the diagnostic procedure prior to attempting any restoration whatsoever. I ask your indulgence, if for the moment, I tell you how I go about a diagnosis.

**DIAGNOSIS**

At the first sitting complete radiographs and impressions for study casts are made. The study casts are mounted on an anatomical articulator. At the second sitting with the radiographs and the study casts before us, we begin the diagnosis. We check our radiographs for diseased teeth; questionable teeth; broken roots; residual infection; *position of pulps; length, shape and number of roots;* density of bone; depth of cavities; conditions under and around old restorations; and any deviation from normalcy of the supporting structures.

We next remove from the study casts all teeth condemned by the radiographs. We also remove from the casts all teeth which cannot be placed in functional occlusion, or any tooth that for any reason must be condemned as an abutment. We now see the mouth as it will be after all condemned teeth have been removed.

Among conditions to be looked for on the study casts, of course, are: the extent of wear on the incisal and lingual surfaces of anterior teeth and the occlusal surfaces of posterior teeth; cuspal interference; vertical relationship of teeth to one another; the number of teeth out of occlusion; rotated teeth; the amount of drifting; spaces created by drifting teeth; extruded teeth; cross-bites; over-bites; end-to-end bites; open-bites; protrusions; length of crown portions; thickness of teeth bucco-lingually and labio-lingually; plus an opportunity to study the casts from a tonsil's-eye view when in centric occlusion.

There are still other abnormal conditions for which we would look, and after

observing them carefully we would then be ready to call in our patient and continue the diagnosis by questioning him. If abnormal occlusion is apparent, we would question the patient about headaches; neurosis; neuralgia about the head and face; grinding of teeth during sleep; tired feeling and muscular aches about the neck and face. If the study casts present any condition of occlusion which in our judgment might be causing undue strain on the temporomandibular joint, we may further question the patient as to his hearing, and about buzzing sounds in the head and dizziness.

In concluding our diagnosis we make a careful study of the mouth, seeking conditions not visible in the radiographs and study casts. We begin by drying each tooth with a blast of compressed air, then with the aid of a very sharp explorer, check every visible break and stain on the enamel. Each tooth is then tested for vitality, and each questionable tooth is brought to the attention of the patient.

We then observe the condition of the surrounding tissues—sharp, irregular, or hypertrophied ridges where teeth are missing; the distance from these ridges to the opposite occlusal surfaces; buckling of gum tissue mesial or distal to drifting teeth; food impactions and general condition of contact points; the degree of mobility of all teeth; sensitive areas around the gingivus; condition of dental work present, and whether or not the patient is taking care of his mouth satisfactorily.

So far we have stressed the necessity of a thorough scientific diagnosis which, incidentally, is the most important fundamental principle this paper has to offer. However, we should not determine the type of restoration to be used until we make thorough plans for the rehabilitation of the mouth.

These plans call for the removal of all teeth condemned by the study casts and radiographs. Next, we remove all cuspal and incisal interferences; reduce all extruded teeth, even though it may be necessary in many instances to protect the sensitiveness caused by this reduction with a restoration of some type. If an extruded tooth, or for that matter any tooth, cannot be placed in functional occlusion, it is better that the tooth be extracted and replaced with a bridge, because it is infinitely more important to gain functional occlusion by means of a proper restoration than to have an abnormal occlusion eventually cause a pathologic condition.

Now, once this balancing of remaining teeth has been accomplished, we proceed, if necessary, with the periodontal treatment of the case, whether surgical or any other technique of your choice. All teeth used for abutments requiring periodontal treatment should be taken out of occlusion to provide rest, allowing teeth to tighten. Then, too, we surgically expose crown portions of teeth that can be used as abutments, and we also surgically prepare ridges to create space where aesthetics and cleanliness are essential.

Once these plans have been completed —then, and only then, is the operator ready to determine the type of restoration to be used. His choice may be that of a fixed or removable bridge, a combination of these two, or any of the other innumerable types of restorations that clutter the profession. However, it is my belief that a fixed-bridge, when a fixed-bridge is possible, and when properly constructed, is preferable to all other forms of restorations, especially so if longevity is desired.

This paper, as by now you will realize, has been concerned particularly with one phase of dentistry. May I offer in this connection one broad observation which may seem to go far outside my special subject here today. I do so only because of my very deep concern about the urgent current need for emphasis and concentration upon the achievement of better actual work; better actual results in what we are doing for our patients. Theory is a wonderful thing. But theory has been fully effective only when it could be put fully into practice. These days we are teaching our young students a vast detail of theory. Fine. If they have time

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## FOR RENT

**For Rent:** Office space desirable for dental office or laboratory. In modern fireproof elevator building at 3600 Fullerton Avenue. Telephone REgent 4-4800.

**For Rent:** Office in the Midwest Tower Building at 1608 Milwaukee Avenue, corner North Avenue. Fully equipped. Three days a week—Monday, Wednesday and Friday. Telephone ARmitage 6-4245.

**For Rent:** In 185 North Wabash Avenue Building, completely equipped modern dental office and laboratory. Large reception room; switchboard service. Available 2 or 3 days a week. Address C-10, The Fortnightly Review of the Chicago Dental Society.

**For Rent:** Office in the Field Annex Building. Completely equipped. Three days a week—Tuesday, Thursday and Saturday, starting May 1. Telephone ARmitage 6-4245.

**For Rent: Office Space; $3.00 Per Foot. Michigan Avenue. Exclusive Medical Building in Loop.** 5,000 Feet; part or all to reputable dentist; choice of space to first applicant. 1½ blocks from I.C. station. October 1 leases or earlier. All applications will be confidential. Address C-14, The Fortnightly Review of the Chicago Dental Society.

**For Rent:** Complete dental office available on busy North side transfer corner. Share reception room with two other doctors. Give age, education, experience, etc. in reply. Excellent opportunity for right person. Address C-17, The Fortnightly Review of the Chicago Dental Society.

**For Rent:** In Oak Park; 1 or 2 offices with reception room, very light, over Rexall Drug Store; reasonable. Excellent location across from bank. Telephone janitor at EUclid 7901 or owner at HOllycourt 5-3481.

**For Rent:** Will convert five rooms into office space, 2 and 3-room units, for dentists or physicians. Located above a drug store at 3400 west and 5600 north. Telephone JUniper 8-3182.

**For Rent:** 2,600 square feet Loop office space. $3.00 per square foot. Short term or long term lease, including options. Individual or form groups. Completely medical and dental building. New limestone front; modern windows; new elevators; modern lobby and halls. X-ray; pharmacy; etc. Lower level parking. Corner South Water and Michigan Blvd. Unusual opportunity for highest caliber men. All applications kept confidential. Only limited number of offices available. No 60-day cancellation clauses as some leases possess. Telephone RAndolph 6-1899.

**For Rent:** Beautiful 2-chair dental suite in Marshall Field Annex. Completely equipped with new Ritter equipment. Several days per week are available. Telephone CEntral 6-3391.

**For Rent:** Would you like an office in an established suite in Chicago's Loop? Plenty of outdoor light; best of transportation. Telephone DEarborn 2-4164.

## WANTED

**Wanted:** Dental assistant. Must be experienced. Five-day week; unusually attractive near North side office. Telephone LIncoln 9-4820.

**Wanted:** Capable and experienced dental assistant for busy dentist in Loop. Must be familiar with x-ray technic and processing of film. Address C-12, The Fortnightly Review of the Chicago Dental Society.

**Wanted:** Air conditioning unit. Must be late model and in good condition. Cash deal. Telephone PAlisade 5-2357.

**Wanted:** To buy—secondhand Ney surveyer and hand piece holder. Telephone BAyport 1-1797.

**Wanted:** Nurse with eight years experience (some dental) wishes to work for dentist who will teach to become dental assistant. Not afraid of hard work. Telephone HYde Park 3-4445.

**Wanted:** To purchase—Loop dental office and good will. Cash transaction. Address C-13, The Fortnightly Review of the Chicago Dental Society.

**Wanted:** Young ethical veteran dentist wishes to purchase active dental practice. Prefers to be near or in Chicago. Will consider northern Illinois. Address C-9, The Fortnightly Review of the Chicago Dental Society.

**Wanted:** Young dentist wishes full or part time position in Chicago. Address C-16, The Fortnightly Review of the Chicago Dental Society.

**Wanted:** Experienced dental assistant; South side. 4½ days a week; no evenings or Saturdays. Good salary. Address C-18, The Fortnightly Review of the Chicago Dental Society.

**Wanted:** An associate. Excellent opportunity in group dental practice. Located in West suburban area. Earnings unlimited. State age, experience, marital status and hobbies. Address C-21, The Fortnightly Review of The Chicago Dental Society.

**Wanted:** A young dentist to become associated with dentist in city outside Chicago. Exceptional opportunity for man interested in future. Address C-23, The Fortnightly Review of the Chicago Dental Society.

**Wanted:** Competent, reliable associate to take over in near future a very successful and highly lucrative practice on Southwest side. Choice, modern, up-to-date in every respect. Ideal lease. Five-room suite; two operating rooms; all fully equipped with new and the finest of equipment. Excellent fees and clientele. Leaving state but will stay until associate has become fully familar with patients and routine. Address C-24, The Fortnightly Review of the Chicago Dental Society.

**Wanted:** Associate to take over successful practice in Evanston. References required. Address C-26, The Fortnightly Review of the Chicago Dental Society.

**APPLICANTS**

*(Continued from page 21)*

TEELING, MATTHEW A. (U. of Ill. 1909) West Suburban, 5 N. Wabash Ave. Endorsed by Donald M. Gallie and Edgar D. Coolidge.

ZUBER, H. G. (N.U.D.S. 1925) North Side, 3304 N. Lincoln Ave. Endorsed by Leonard C. Chapman and Nathan H. Rosen.

**NEWS AND ANNOUNCEMENTS**

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## POSTGRADUATE COURSE AT THE UNIVERSITY OF ILLINOIS

"Dentistry for Children," a new course covering the clinical aspects, will be offered at the University of Illinois College of Dentistry starting April 25. The course is designed to answer some of the common problems that confront the dentist who deals with children. Those problems include rampant caries, pulp treatment, fractured teeth, space maintenance, habits of children and management techniques. This course will extend over a period of six weeks with sessions conducted from 7 to 9 p.m., every Monday from April 25 through May 30.

The faculty for the course will consist of outstanding lecturers who will present their particular approach as well as the results of their investigations. Lecturers are Dr. Joseph Hartsook, University of Michigan; Dr. Henry M. Wilbur, University of Louisville; Dr. Samuel Stulberg, University of Detroit, and Dr. Maury Massler, University of Illinois.

For further information, write to Dr. Isaac Schour, University of Illinois College of Dentistry, 808 South Wood Street, Chicago 12, Illinois.

## DEAN FREEMAN ADVOCATES MORE RESEARCH

Dean Charles W. Freeman of Northwestern University Dental School spoke before the Northwestern University Associates recently and urged a greatly expanded program of dental research. He declared that it is a hard fact of life that a 65-year-old businessman may be "dentally young," whereas a college junior of 20 may be "dentally old."

The real problems to be licked, Dr. Freeman told the group, are dental decay and gum diseases for these are the sources of most of the dental troubles that cause tremendous losses to the nation as a whole. The seriousness of the problem is pointed up by the fact that, at present, more than 90 per cent of young people are afflicted with dental decay.

## NEWS LETTER NOW AVAILABLE TO EVERYONE

The American Dental Association news letter which has been circulated only among American Dental Association officers, trustees, committeemen and delegates, and editors and officers of constituent and component societies, is now available to the general membership of the Association. The price for the annual subscription has been set at $1.50.

## BILLS CALLING FOR ADMINISTRATIVE PARITY INTRODUCED

The long awaited administrative reorganization of the Army Dental Corps got off to a good start last month with the introduction of identical bills in the Senate and in the House of Representatives. The bills are so worded that, if passed, dental officers will have "the right and duty" to administer matters relating to the dental health of army personnel. The bills provide that the head of the dental corps shall be an assistant to the army Surgeon General and that the dental surgeon at each command or installation shall be responsible to the commanding officer for the dental health of the command and be responsible for all dental personnel.

## DR. STANLEY D. TYLMAN GETS AWARD

The highest honorary degree by the University of Buenos Aires, "Doctor Honoris Causa," was recently presented to Dr. Stanley D. Tylman by Argentine President Juan Peron.

Dr. Tylman made a two-month visit to South America and presented a series of lectures and clinics at the Universities of Buenos Aires and Cordoba. While there he became a public figure overnight when he was called in consultation by President Peron. He was so alarmed by the seriousness of the president's condition that he insisted on a conference with Argentine specialists after the dentist on the case had muffed the diagnosis.

## WISCONSIN MEETING APRIL 19-21

The Wisconsin State Dental Society will hold its 79th Annual Meeting at the Milwaukee Auditorium and Hotel Schroeder in Milwaukee, April 19 through 21.

Essays, registered study courses, an imposing array of scientific and health exhibits, the annual luncheon on April

19 and the annual dinner dance on April 20 are among the features. On Thursday afternoon, April 21, a program of sixty-seven table clinics will be presented.

Among the essayists who will be present are Drs. Edward J. Ryan, Howard A. Hartman, Alfred E. Seyler, Allen O. Gruebbel, Henry B. Clark, Jr., Harry A. Tinker, G. C. Paffenbarger, Jerome M. Schweitzer and Sidney C. Fournet.

Members of the Chicago Dental Society are cordially invited to attend the sessions.

### DR. FRANK A. TRAGER
### 1880-1949

Dr. Frank A. Trager, a West Suburban dentist for over thirty years, died at Hines Hospital on March 8, 1949. He was a graduate of Northwestern University Dental School in 1906.

Dr. Trager was a marine captain in World War I and a member of the American Legion since that time. His son, Frank P., survives him.

### DR. THERON B. CHILDS
### 1880-1949

Dr. Theron B. Childs, a life member of the Chicago Dental Society and a member of the North Side Branch, was killed in an automobile accident on January 7, 1949.

Dr. Childs practiced for many years on Morse Avenue in Rogers Park and lived in Glencoe. He was graduated from Loyola University School of Dentistry, Chicago College of Dental Surgery, in 1907. He is survived by his widow, Florence; two daughters, Theda and Adelaide; a son, Theron; and three grandchildren.

### DR. JOSEPH P. CRUISE
### 1868-1949

Dr. Joseph P. Cruise, a life member of the Chicago Dental Society and the Illinois State Dental Society, passed away on March 2, 1949. He was affiliated with

the West Side Branch of the Chicago Dental Society.

Dr. Cruise was graduated from Loyola University School of Dentistry, Chicago College of Dental Surgery in 1898 and practiced at 4357 West Madison Street. He is survived by his widow, Maude, and a brother, Dr. Robert J. Cruise. He was the son of the late Sir Francis R. Cruise, M.D., D.L., K.S.G., and Lady Cruise.

## DR. NEIL O. ROGERS
## 1885-1949

Dr. Neil O. Rogers, a member of the Kenwood-Hyde Park Branch of the Chicago Dental Society, died of a heart attack on March 3, 1949. He maintained his office at 1525 East Fifty-third Street.

Dr. Rogers was graduated from Northwestern University Dental School, Class of 1912, and served on numerous committees of his Branch and of the Chicago Dental Society. He is survived by his widow, Marion; a brother, Charles; and a sister, Mrs. Pearl Dodge.



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the installation of officers on April 12. Good luck to all! . . . Frank LaPata, a new member, is going to spend three weeks vacationing in Canada. . . . William Sutcher went to New York and attended the Dewey School of Orthodontics. . . . Ralph Ball has transferred from Evanston to our branch. A hearty welcome! . . . B. T. Apke is going to French Lick, Indiana for a few days' rest. . . . Our deepest sympathies go to Joseph Gorman, whose sister just passed away. . . . John J. Reilly has returned to his office after a physical checkup at a hospital. . . . Your correspondent has finally received his new "super-drooper" Ford. . . . The Lawndale Dental Club also holds its final and gala meeting of the year in May. This, without doubt, is the liveliest meeting of its kind in the field of dentistry!! Plan to attend. Don't forget the annual outing in June.—*Herman Nedved, Assistant Branch Correspondent.*

**OBTAINING LONGEVITY IN FIXED-BRIDGE RESTORATIONS**

*(Continued from page 20)*

for it; if they can spend the first half of their lives getting ready to practice; if they have the finances to do so. But we all know that there are very practical limits to what any of us can do. We desperately need just now, more competent, dependable, thoroughly professional mechanics; men who can use their hands. To my mind that means that the time and teaching given to theory should be carefully limited—limited in general terms perhaps to the theory that can be used and put into practice. If more theory can be injected without inconvenience and within decent time limits into the student, and he can take it in stride—all right. But, you know—too much is too much. I'll let it go at that. And, too little of actual capacity to do good dentistry is too little and it is more than that—it is tragic. Theory, yes. All that can be digested. All that can be used by practice; competent practice; that is our business in the end; that is our responsibility. So—in closing, if we are to be dentists—let's be ourselves; let's be dentists and be proud of our achievements; and be proud of what dentistry has contributed to the health and welfare of our people.

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